DR. GARY KRUEGER, D.D.S. / C.D.T
Board Certified Prosthodontist / Certified Dental Technician

Patient Registration Form

Today's Date _____

Name_____
Last *First* *Middle*

Home Phone (_____) _____

Cell Phone (_____) _____

Number, Street
Address_____

City _____ State _____ Zip Code _____

Occupation _____

Business Phone (_____) _____

Date of Birth _____/ _____/ _____ Sex M F

E-Mail _____

Name of Spouse _____

Closest Relative _____

Phone (_____) _____

If you are completing this form for another person, what is your relationship to this person? _____

Who may we thank for referring you to our office? _____

Release for Treatment:

I authorize DR. GARY KRUEGER and any other agents or employees as selected by him to treat me. This treatment may require the administration of local anesthetics (EXCEPT for _____, which I am allergic to). Although these anesthetics are used for my benefit, they may occasionally cause inflammation, allergic reaction, pain, nerve damage because of anatomic variations, fainting and high and/or low blood pressure.

I authorize DR. GARY KRUEGER to photograph me for use on educational and teaching purposes.

SIGNATURE: _____ DATE _____

PRINT NAME _____

320 Santa Fe Drive, Suite 201 / Encinitas, CA 92024
Phone: (760) 479-0961 / Website: www.kruegerdds.com / E-Mail: gkrueger@kruegerdds.com

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MEDICAL HISTORY

Patient's Name _____ Age: _____

What brings you to our office? _____

_____

Have you been a patient in a hospital in the last two years? Yes☐ No☐

Has a physician treated you in the last year? Yes☐ No☐

Doctor's name: _____

Have you taken any prescribed medications or drugs in the last two years? Yes☐ No☐

Please list all medications or drugs:

_____ _____ _____

_____ _____ _____

Are you, or have you ever been on any weight reduction Medicine (e.g. Fen-Phen)? Yes☐ No☐

Do you smoke tobacco, or use smokeless tobacco? Yes☐ No☐

Have you ever had a problem with dental, local or general anesthetic? Yes☐ No☐

Check the following ones you are allergic to:

Penicillin☐ Sulfa☐ Antibiotics☐ Codeine☐

Iodine☐ Aspirin☐ Local Anesthetics☐ Latex Gloves☐

Other: _____

Are you allergic (i.e. itching, rash, swelling) to or made sick by any drugs, medications, or doctors treatment? Yes☐ No☐

HIPAA Consent & Acknowledgement Form

I,_____ do hereby Consent and Acknowledge my agreement to
Patient or Guardian
the terms set forth in the "HIPAA INFORMATION FORM" and any subsequent changes in office policy. I understand that this consent and acknowledgement shall remain in force indefinitely.

I acknowledge that I have received a copy of the Dental Materials Fact Sheet version issued in 2004.

_____
(patient signature) *(date)*

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Check if you have ever had any of the following

Heart Disease ☐
Heart Attack ☐
Angina ☐
High Blood Pressure ☐
Low Blood Pressure ☐
Heart Murmur ☐
Mitral Valve Prolapse ☐
Rheumatic Fever ☐
Scarlet Fever ☐
Artificial Heart ☐
Heart Pacemaker ☐
Congenital Heart Defects ☐
Heart Surgery ☐
Prosthetic Joint ☐
Anemia ☐
Chemotherapy ☐

Stroke ☐
Kidney Trouble ☐
Ulcers ☐
Emphysema ☐
Tuberculosis (TB) ☐
Asthma ☐
Hay Fever ☐
Sinus Trouble ☐
AIDS or HIV Infection ☐
Diabetes ☐
Thyroid Disease ☐
Cancer ☐
Leukemia ☐
Cortisone Medication ☐
Radiation Treatment ☐
Arthritis ☐
Rheumatism ☐

Glaucoma ☐
Pain in Jaw Joints ☐
Allergies or Hives ☐
Hepatitis ☐
Liver Disease ☐
Yellow Jaundice ☐
Drug or Alcohol Addiction ☐
Blood Transfusion ☐
Hemophilia ☐
Venereal Disease ☐
Epilepsy or Seizures ☐
Nervousness ☐
Sickle Cell Disease ☐
Bruise Easily ☐
Psychiatric Treatment ☐
Fainting or Dizzy Spells ☐

Do you have any disease, condition or problem not listed? Yes☐ No☐

Women:
Are you pregnant now? Yes☐ No☐
Do you anticipate becoming pregnant? Yes☐ No☐
Are you taking birth control medication? Yes☐ No☐

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will inform the doctor at the next appointment without fail.

Patient's Signature _____ Doctor's Signature _____ Date _____

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